Board of Medical Licensure and Discipline

In the Matter of **Michael T. Judge, D.O.**

ORDER OF SUMMARY SUSPENSION

The Board of Medical Licensure and Discipline ("Board") received a series of complaints regarding Michael Judge, D.O. ("Respondent") alleging quality of patient care issues, prescribing narcotic agents inappropriately and allegations of Medicaid fraud. The Respondent had been placed upon probation by the Board in March 2000 for filing deceptive claims and misrepresenting material facts in the practice of medicine relating to personal injury claims.

The Board reviewed nine patient records that it obtained from the Respondent. In each of the cases, patients were receiving narcotic medications over a period of many years. The Board reviewed the care and treatment rendered by the Respondent to these patients and presented its findings to the Respondent who provided a detailed explanation of his treatment of these nine patients to the Board.

The Board reviewed the records again and considered the response provided by the Respondent to the Board's concerns. The Board has concluded the following with respect to the overall quality of care provided by the Respondent:

1. The records lack a comprehensive initial history and physical examination
2. The records lack a comprehensive annual history and physical examination
3. Significant disease history provided by the patient on the "Review of Systems" were never addressed.
4. There is no evidence of preventive care and disease risk assessment.
5. Laboratory studies indicating abnormalities such as hyperlipidemia and hyperglycemia were not followed or addressed.

6. Pain management included chronic use of narcotics and opiates which were not indicated for such conditions as carpal tunnel syndrome, headaches and disk disease.
7. There was no documentation that the patient was informed regarding the potential for addiction to these medications that included Oxycontin, Valium, Vicodin, Fiorinal, Lortab, Dilaudid and hydrocodone.
8. The records failed to demonstrate the minimum standard of acceptable care in terms of charting care rendered and medical follow-up of positive symptoms.

The Board finds the following deficiencies with respect to the following patients:

Patient A

Patient A was seen by the Respondent from May 1999 through October 2001 for TMJ, asthma and cervical and lumbar disc disease. The patient reported a history of "cancer, asthma, bronchitis, nausea and vomiting, diarrhea, blood in the stool, hemorrhoids, head and neck radiation, headache, low back problems, anxiety and depression" The patient was treated with Valium, Vicodin ES and antidepressants. There is no evidence of a full history, physical examination, laboratory studies or investigation of her positive "Review of Systems". On April 16, 2001, the patient presented to the Miriam Hospital for a laceration. There is a notation for syncope, bradycardia prior substance abuse for which the patient was on methadone treatment. The following day, she was admitted to Roger Williams Hospital for chest pain. A comprehensive history taken there revealed long standing depression, PSA, bi-polar disorder, ulcerative colitis, anxiety and asthma. The Respondent did not pursue an investigation or referral regarding the bi-polar disorder. Vicodin was discontinued and later Valium was changed to Klonopin. During a subsequent office visit, the patient complained of a flare up of colitis and she had a systolic pressure of 84. No abdominal or rectal examinations were noted, laboratory tests were not ordered and no referral to a gastroenterologist was made.

Patient B

Patient B was under the care of the Respondent from January 2000 through September 2001. She was a prior patient of HPHC of New England for lumbar strain, depression, migraine headaches, mild carpal tunnel syndrome, sinusitis, bronchitis and smoking. She was initially started on Zoloft and allergy medications. She was followed every two months for carpal tunnel syndrome. She was treated with Valium, Fiorinal and Vicodin from August 2000. She was referred for evaluation and surgical correction of the carpal tunnel syndrome. No indication is present for the prescription for Vicodin every four to six hours.

Patient C

Patient C was seen by the Respondent between November 1999 through September 2001 for lumbar disk disease, documented since 1991, COPD, carpal tunnel syndrome,

depression and anxiety. The records lack a summary of prior treatment and a minimal physical examination. He was started immediately on Vicodin and followed monthly and maintained on Lortab and Oxycontin. The patient's occasional hypertension is never addressed nor are there any trials of NSAIDS, repeat MRI studies, neurological or orthopedic evaluations or trials of physical therapy.

Patient D

Patient D was under the care of the Respondent from January 1993 to May 1994 (when he moved to Texas) and again upon his return to Rhode Island from December 1997 through October 2001. He was treated for lumbar disk disease that was surgically corrected in 1992. The Texas medical records reveal a family history of heart disease and a patient reported history of cardiomegaly and hypertension. Treatment of the lumbar pain did include spinal steroid injections and TENS unit without reported benefit. A lumbar fusion was discussed. Upon return to the care of the Respondent, the patient was placed on Lortab and Oxycontin. No further notation of the family history was made. The patient had several elevated blood pressure readings which were never treated.

Patient E

Patient E was under the care of the Respondent from July 1987 to April 2001 for hypertension, anxiety and osteoarthritis. In 1996, when he complained of arthritis pain, he was treated with Tylenol with codeine. In 1997, laboratory tests revealed hypercholestrolemia and hyperglycemia without treatment or subsequent evaluation until October 2001 when the LDL was reported elevated. No treatment was instituted. In 1999, the patient complained of bright red blood in the rectum but no colon screening tests were instituted. The patient was a smoker but no oral examination was undertaken by the Respondent. In 2000, a 7.5 cm mass was discovered by the patient's family in the patient's palate. The mass was later excised.

Patient F

Patient F was under the care of the Respondent from December 1999 through October 2001. He was a prior patient of Harvard Pilgrim of New England with a documented history of lumbar disk disease with prior treatments of NSAIDS, epidural injections, chiropractic care and neurosurgical evaluation. Several of his the patient's prior health care providers expressed concern about his chronic need for Vicodin. The patient was not thought to have a surgical condition. The Respondent started the patient on naprosyn and Vicodin and later, Vicodin and Oxycontin. A repeat MRI did not show progression of the disease. There was no orthopedic, neurosurgical or physical therapy referral.

Patient G

Patient G was under the care of the Respondent from 1984 through 2001 for a well documented history of gout, degenerative arthritis, hypertension and hyperlipidemia. The Respondent maintained the patient on Dilaudid 4 mg throughout the treatment years with

office visits every three weeks for refills. There are no metabolic studies regarding his hyperuricemia and hyperlipidemia following those done in 1984. The patient refused blood pressure medication.

Patient H

Patient H was under the care of the Respondent since 1984 for a history of vascular headaches which was diagnosed by another physician who recommended Elavil or a calcium channel blocker. Instead, the patient was maintained by the Respondent on Vicodin and Oxycontin. The patient's course was complicated by Barretts Esophagitis, repeated upper GI bleeds and a laporascopic cholecystectomy. There is scant reference to these problems in the Respondent's records.

Patient I

Patient I was under the care of the Respondent from September 1996 through February 2002. She was treated for headaches, mild degenerative changes of the C-spine and lumbar pain. She had a negative MRI. The patient was maintained on hydrocodone and Oxycontin. The patient's psychiatrist has expressed concern over "polypharmacy."

SUMMARY

The Board's review of the care and treatment rendered to these patients indicates poor assessments of patient's symptoms, inadequate follow-up of positive findings, maintaining patients on opiate and narcotic medication without adequate indication for such therapy. The Board's review of the Respondent's records indicates that the Respondent's care and treatment of these patients failed to meet the minimum standards of acceptable care. Further, during much of the time referenced above, the Respondent's license to practice was on probation for filing deceptive claims and misrepresenting material facts in the practice of medicine. Accordingly, the Board finds that the Respondent has violated the terms of his probation.

ORDER

After considering the recommendations of the Investigating Committee along with the records and prescribing patterns of the Respondent, I find that the continuation in the practice of medicine of Michael T. Judge, D.O. would constitute an immediate danger to the public. Accordingly, license number DO 00287, issued to Michael T. Judge, D.O. is hereby suspended until further Order of the Board of Medical Licensure and Discipline. The Respondent is entitled to a hearing pursuant to R.I.G.L. 5-37-8 within 10 days of the effective date below.

Patricia A. Nolan MD, MPH
Patricia A. Nolan, MD, MPH
Director of Health
Chair, Board of Medical Licensure and Discipline

CERTIFICATION

I hereby certify that a copy of this ORDER was hand delivered Mail to Michael Judge, D.O., and Jay Elias, Esq., 321 South Main Street, Suite 300, Providence, RI 02903 on this 17th day of April 2002.

Bruce McIntyre